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ABSTRACT

Literature concerning problems that result from teenage pregnancy is synthesized and reviewed. The first section briefly compares rates of pregnancy among adolescents in the United States against those of other countries. This comparison is discussed in greater detail in the second section, which focuses on pregnancy rates in Connecticut and the United States in general. Causes and associated factors of teenage pregnancy are discussed in the fourth section. The stages include: prevention, treatment, and rehabilitation. Programs which attempt to provide these opportunities are described. Forty-eight references are cited in the bibliography. (CB)

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A REVIEW OF LITERATURE ON COPING WITH TEENAGE PREGNANCY IN THE COMMUNITY

by
Moses Stambler

Background paper for the Conference on Teenage Pregnancy in the Community
at

Southern Connecticut State University
May 15, 1985

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A REVIEW OF LITERATURE
ON
COPING WITH TEENAGE PREGNANCY IN THE COMMUNITY

A) A COMPARATIVE PERSPECTIVE

B) TEENAGE PREGNANCY PROBLEMS: The U.S.A., Connecticut

C) CAUSES AND/OR ASSOCIATED FACTORS OF TEENAGE PREGNANCY

D) STAGES FOR INTERVENTION: PREVENTION, TREATMENT, REHABILITATION

National Legislation State Proposals, Local Efforts

A) A COMPARATIVE PERSPECTIVE

Teenage pregnancy generally results in long-range adverse health, social economic & demographic affects for any nation. For industrialized nations such as the U.S.A. these effects may include the following: (Population Reference Bureau, 4)

> Rates of illness and mortality are significantly higher for teenage mothers and their infants than they are for older mothers. Early initiation of childbearing is likely to mean truncated education, lower future family income, and also larger completed family sizes, which, along with shorter time spans between generations, contribute to rapid population growth.

When compared to other industrialized nations (Canada, France, the Netherlands, Sweden and Great Britain), teenage pregnancy rates have been found to be higher in the U.S. than in any of the other five countries. The Alan Guttmacher Institute Report noted a U.S. rate of approximately 60 per 1,000 women ages 15-17 with England, France, Canada and Sweden ranging only between approximately 18 to 30 per 1,000 women, and the Netherlands below 10.

The Guttmacher report rejects the idea that the high U.S. rates can be explained by the very high fertility rates among black teenagers, nearly twice that of whites. They note that 83 out of 1,000 white Americans become pregnant between ages 15 and 19, nearly twice the rate of the next highest nation Great Britain. (A Teenage Pregnancy Epidemic, 90)

The U.S. rate for abortions is higher with 60 out of 1,000 U.S. teens have had at least one abortion by the time they reach 18. It is the only developed nations in which the pregnancy rate has been increasing for the past several years.

We are "... saddled with a teen pregnancy rate so high than four in 10 of today's 14 year-olds will become pregnant at least once by age 20." (Scales, 6?)

B-1 TEENAGE PROBLEMS IN THE USA AND CONNECTICUT

THE U.S. SITUATION

It is probable that unmarried teenagers' sexual activity is extensive in all developed nations and that a substantial number of teenagers are sexually active (Research Report, 6)

> The increase in adolescent pregnancies is related to an increase in the number of teens who are sexually active. In the early 1970s, religious affiliation, race, residence, and socioeconomic status were all considered to be related to age of first intercourse. However, there is evidence to suggest that these distinctions are beginning to disappear as premarital sexual activity increases among all elements of the adolescent population.
>
> Eight in 10 males and 7 in 10 females have reported having intercourse while in their teens. While age for age the proportion of sexually active black teens continues to be higher than that of whites, the gap between them has closed considerably in recent years.

The out of wedlock pregnancies of teenagers 15-19 has been increasing since 1970. (Population Bureau, 15)

> ... in the U.S. between 1970 and 1982, the proportion of all births to women aged 15-19 that occurred out of wedlock rose from 17 to 37 percent among white women and from 62 to 87 percent among black women. The proportion of total births to all women under 20 that were out-of-wedlock was 51 percent in the U.S. in 1982, 52 percent in England and Wales in the same year, and 38 percent in France in 1980.

These days, (Research Report, 3)

> Fewer adolescents marry to legitimate out-of-wedlock pregnancies but rather keep their child outside of marriage or choose to have an abortion. While teenagers represent only 18% of sexually active women capable of becoming pregnant, they account for 46% of all out-of-wedlock births and 31% of all abortions. Of the approximately 1.3 million children currently living with teenage mothers, more than half are living with unwed mothers.

B-2 TEENAGE PREGNANCY PROBLEM IN CONNECTICUT

In Connecticut, there are over 375,000 teenagers 13-19 and another 125,000 children between 10 and 12 years old. On the basis of national norms, it is reasonable to assume that nearly half of the first group has had sexual intercourse. In addition, one of every 10 babies born in the state of Connecticut is born to a teenager. This is double the ratio of thirty years ago. (Research Report, 6)

The Research Report notes that,

> In 1980, 11.4% of total live births in Connecticut were born to mothers under age 20. Over 50% of the births to Connecticut teenage mothers in 1978 were classified as illegitimate. In addition, about one-third of reported abortions occurring in Connecticut are to girls under age 20.

Teenage fertility rates in Connecticut reflect a continuing problem. There have been increases for the 10-14 year old group but decreases for the 15-19 year old group.

Calendar Year	Females 15-19 years. old:			Female 10-14 years. old		
	Estimated population:	# of births:	Fertility rate:	Estimated population:	# of births:	Fertility rate:
1955	74,300	2,919	39.3	82,000	14	0.2
1960	84,535	4,521	52.9	109,280	25	0.2
1965	106,700	5,199	48.7	130,000	48	0.4
1970	131,411	5,841	44.4	150,070	83	0.6
1975	137,900	4,585	33.2	137,000	82	0.6
1976	139,900	4,418	31.6	135,300	75	0.6
1977	141,000	4,368	31.0	132,000	94	0.7
1978	142,800	4,347	30.4	130,000	79	0.6
1979	141,000	4,517	32.0	128,100	94	0.7
1980	142,108	4,334	30.5	125,000	70	0.6
1981	138,610	4,321	31.2	120,760	63	0.5
1982	137,820	4,278	31.0	118,670	74	0.6

Source: Department of Health Services

> The largest cities - accounted for nearly half of all teen-age births (46.8%): Hartford (679 babies) Bridgeport (557 babies), New Haven (438), Waterbury (232) and Stamford (135). The addition of medium-size cities like New Britain, Bristol, Norwalk and Danbury raises the percentage to 62%. "This suggests that the teen pregnancy problem is definitely not limited to urban areas -- it is a suburban and rural problem as well. In Putnam 21% of all births in 1982 were to adolescents (25 babies); in Thompson it was 17% (20); in East Haddam 12% (10).

Report of the Task Force for 1982

The Task Force Report presented the following 1982 figures on teenage pregnancy for all of Connecticut. (Report of the Task Force, 9)

1. An estimated 9,730 Connecticut teenagers became pregnant.
2. Teenage girls accounted for 16% of all pregnancies in the state.
3. Over 200 girls between ages 10 and 14 became pregnant.
4. One of every ten babies born in Connecticut had a mother younger than 20.
5. At least 5,378 teenagers had abortions.
6. Nearly 1/3 of all abortions performed in the state were on teenagers.
7. Girls under 19 had 1,000 more abortions than live births.

For 1983, 9,498 teens in Connecticut became pregnant, and 255 of these pregnancies were to girls 14 or younger. (Lane and Browder, 85-87)

In the month of December 1984, the high fertility rate of teenagers resulted in high fiscal costs to Connecticut (Research Report) Over half of the women receiving AFDC in Connecticut were teenagers when they had their first child, and the benefits for these 21,654 women and their children cost the state an estimated $5,000,000 in this month alone.

C. CAUSES AND/OR ASSOCIATED FACTORS FOR TEENAGE PREGNANCY PROBLEMS

There are four major perspectives about teenage pregnancy that affect the focus and types of services one provides. Each perspective reflects a bias and basic perception of the problems. These are: (Cvetkovich, 16)

1. Biological perspective that would consider the change in the teenager's physical ability to conceive and carry a child to term.

2. An individual difference perspective that would consider personality and other individual characteristics that may place some teenagers at greater contraceptive risk than others.

3. A life cycle perspective that would consider the emotional, intellectual, and social development that characterizes adolescence as a unique developmental period.

4. A generational perspective that would consider how members of one particular cohort are similar to each other and are different from other cohorts. This perspective would consider, for example, changes in attitudes toward premarital sex that were developing in the 1960's. On a broader level, this generational perspective would blend into a cultural perspective that would consider similarities shared by individuals as members in a social group.

Kingsley Davis, the anthropologist, has noted some broad cultural perceptions and anthropological perspectives applicable for understanding teenage pregnancy. (Davis, 309)

> Fundamentally, the problem of teenage pregnancy is that in industrial societies the teenager is not a full adult and, consequently, not ready to undertake the grave responsibility of creating and rearing a human being. He is, of course, an adult from the standpoint of reproductive biology, a circumstance that creates

> the problem in the first place, but not from the sociologic, legal, and economic points of view. Ironically, as the age of biological adulthood has fallen (as seen in the younger age at menarche), the age of social adulthood has, for several reasons, become older. Not only does an advanced technology demand more skills and hence more training than an agrarian society, but alternative careers multiply and the information necessary to decide among them becomes more voluminous. Further, affluent societies can afford the luxury of a longer childhood, and as the life-span lengthens, the individual has less reason to foreshorten his youth. Of course, the incompatibility between organic and social adulthood is not the same throughout the teen years, because at puberty the maturation process moves swiftly. A boy of 15 is less ready for fatherhood than one of 19. But the community even tries to guide individuals aged 18 and 19 to protect them from fateful mistakes.

Davis notes the changing nature of the social context as a prevention or facilitating force for teenagers becoming pregnant. (Davis, 328)

> If our interpretation is correct that premarital sexual exposure, willingness to take a risk, willingness to bear a child out-of-wedlock, and early marriage, have been the main factors in the large share of adolescents in American reproduction, we must go on to ask how these factors happen to exist to an unusual degree in the United States. To answer that question, at least speculatively, let us begin by recalling the conditions of an earlier time, when teenagers played a lesser role in childbearing.
>
> The key to the old system seems to have been that teenagers were held responsible for any children they engendered. They were held accountable by parents and relatives, by neighbors and acquaintances, and by official representatives of the community. Sanctions included use of force with respect to the father, if necessary, and ostracism and loss of reputation with respect to the mother.

> Inasmuch as sex roles were clearly ascribed, the controls were different for boys and girls. It was in a girl's best interest to marry, because through marriage she gained a source of economic support and was privileged to bear children respectably.

He notes why the old system of constraints changed and the prevention system no longer is in place (Davis, 330)

> ... why did the old system of social control over teenage reproduction weaken? The answer can possibly be found in those social changes that have undermined the authority and power of the nuclear family, kin, and local community with respect to children. In the rising geographical and social mobility associated with industrialization and urbanization, the nuclear family has increasingly become dissociated from the wider circle of relatives. In dealing with the family's adolescent members, therefore, parents have little backing from uncles, aunts, cousins, and grandparents. More importantly, nonfamilial agencies, or third parties, have tended to intrude themselves between parents and children, taking over all or part of what traditionally were parental functions and hence assuming parental authority. These agencies, despite their protestations, often do not strengthen the family and may compete with it. They are, on the whole, achievement groups rather than inheritance groups. They are usually arms of the Government, and they justify their work in terms of the child's welfare or that of society at large. Schools take charge of the child's education, inculcating in him ideas that often contradict those of parents; courts decree the busing of children to schools outside of the neighborhood, regardless of parental wishes; social welfare agencies take over the support of mother and children, often ignoring the father; health agencies offer abortion and contraception to teenagers without parental consent; adoption agencies decide who can adopt children and who cannot.

Unfortunately, the growth and competition of family replacing agencies is defined more by sociotechnical forces not under our control than by will and design.

There are other perceptions and ideas which help explain the cultural and fundamental causes of teenage pregnancy in our society.

The periods of identity and role problems facing adolescents are particularly difficult transitions in developed industrialized nations. As noted by James Chui (quoted by Population Reference Bureau, 4)

> In many developing countries, especially in rural and underdeveloped areas, a girl is often considered to be an adult at the time when menstruation is established regularly. They tend to marry early and do not go to school. The transition from childhood to adulthood in such cases is quick, and the notion of adolescence does not exist. On the other hand, in developed countries and increasingly in urban areas of developing countries where rapid social changes are taking place with modernization, young people go to school and tend to marry late. There is a long transition from childhood to adulthood, and the notion of adolescence emerges.

Diane Burden views an association, if not cause, from a sociological feminist position. "... The incidence of teenage pregnancy appears to be directly related to the increase of female-headed single-parent families in this country and thus is related to the increasing incidence of poverty among female-headed families both black and white." (Burden, 11)

There is also a viewpoint that teenage pregnancy may in some cases be "intentional" to meet the psycho-social needs of youth in transition. (Population Reference Bureau, 21)

In a study by Joseph Scott, intention is suggested. (Scott, 889)

> This study questions the findings of most research claiming that teenage pregnancies are generally unwanted, unplanned and unintended. It starts with the question of why most sexually active teenagers put themselves at risk of becoming pregnant if they do not desire it. The hypothesis is that sentiments of "love" and "aspirations for marriage" are related to starting sexual activity and subsequent pregnancy. The sample is 123 school-age mothers. It was found that sentiments of "love" were associated with becoming pregnant more than with starting sexual activity. Most of the respondents who were "in love" at the onset of pregnancy were hoping to marry their sex partners and, in fact, many though that marriage would occur in the very near future following the outcome of pregnancy. These findings suggest that more research needs to be directed at the development of affective bonds with and the aspirations for marriage to the sex partners. Such research may explain why these teenagers put themselves at risk.

Stuart Cohen also suggests a strong possibility of intent. (Cohen, 210)

> Recent evidence indicates that many teenagers, despite access to birth control information and services, are choosing not to utilize them, and, therefore, are becoming intentially pregnant. Several studies have begun to provide reasons for this new dilemma and profiles of those teenagers who become intentially pregnant. New strategies have to be developed by health care professionals to combat this problem. Some suggestions are presented.

If intention is the case "... new strategies are needed to combat the problem - sex educators, family planning counselors, school guidance counselors, youth agency works, parents, the clergy, physicians and mental health and human behavior professionals - face a major challenge. (Cohen, 211)

Other studies suggest it is not the intention but an incorrect perception, based on adolescent needs, that may lead teenagers to fantasize about the virtues of pregnancy. (Population Reference Bureau, p. 21)

> A young women's view of her future and her understanding of how pregnancy and its consequences might affect that future are highly determinative of her ability to prevent early childbearing. Young people tend to have difficulty making realistic plans for the future and seeing the longer-term effects of current actions. Typically, adolescent females underestimate the obligations of raising a child and are unrealistic about relative costs and benefits. A young woman may perceive that becoming a mother will give her adult status and someone to love her but fail to anticipate what motherhood will cost her in lost membership in her peer group, participation in age-appropriate activities, and abruptly curtailed educational and vocational possibilities. As researcher and social analyst Joy Dryfoos puts it:
>
> "Unless a young woman believes that childbearing during adolescence will limit her opportunities in life and that foregoing maternity will result in enhanced life options, she is not likely to protect herself sufficiently against pregnancy even though she does not particularly want to become a parent."

This approach would suggest (consistent with the philosophy of the Population Reference Bureau), that education to social responsibilities and sex education could be important for dealing with the causes of teenage pregnancy. (Population Reference Bureau, 21)

> In some countries, the majority of adolescents who become pregnant do so unintentionally. As of 1978 in the U.S., for example, unintended pregnancies accounted for 86 percent of all those that occurred to

> unmarried adolescents and 51 percent of all pregnancies among married teenagers. There are numerous reasons for these failures, including ignorance of the reproductive process and of birth control methods and availability, and not believing that intercourse - or a subsequent pregnancy - would take place.

The prudish cultural attitudinal factors, in the U.S., limit the use of contraceptives as suggested by the Guttmacher Institute. (A Teenage Pregnancy Epidemic, 90-91)

> One major difference among surveyed countries is the relative use of contraceptives; although the statistics are confusing, because each country keeps them differently, the institute concluded that "it is likely that the United States has the lowest level of contraceptive practice among teen-agers of all six countries." In particular, American teen-agers are much less likely to use the most effective method of contraception: birth-control pills. This reflects, among other things, a more conservative medical approach in the United States, where, for example, physicians routinely require a pelvic examination before prescribing pills, a complication that may have the effect of discouraging some young women.

The institute's also remarked about moral values. American culture is not sex-obsessed, but prudish, intolerant of premarital sexual activity and unwilling to deal with sexual topics openly.

The institute saw a link between the relatively conservative sexual attitudes of most Americans and the fact that they are more likely than Englishmen, Dutchmen, Frenchmen, Canadians and Swedes to go to church and believe in God.

A Johns Hopkins University based study focuses on the lack of sex education in the United States as a cause for teenage pregnancy. (Scales, 9?)

> ... teen-agers whose sexuality education has included information about contraception have lower pregnancy rates than those without that information. Yet, this is the information that falls first under the censor's knife.
>
> Mathtech, a Washington, D.C., research and consulting firm, conducted the most comprehensive overview ever done of the field of sex education. It concluded that no more than 10 percent of the nation's teen-agers receive a comprehensive education program that covers contraception and includes opportunities for examining values and building self-esteem and communication and decision-making skills.

STAGES FOR INTERVENTION: PREVENTION, TREATMENT, REHABILITATION

Three time-frames or stages provide an opportunity for intervention in teenage pregnancy: 1. Prevention 2. Treatment 3. Rehabilitation. The prevention stage focuses on preventing teenage pregnancies and births through such programs as sex education, contraception, moral persuasion and strengthening family life. There is general agreement that prevention is best but disagreement on appropriate methods of intervention. Pregnancy prevention through sex education and contraception services for teen-agers are positively supported by such groups as Planned Parenthood, but may be viewed as part of the problem by others. Jan Sussex notes three alternative paths to adolescent sexuality. (Sussex, Readings, 168)

> (1) We could decide they can't be allowed any freedom at all and deny it to them - in which case all early adolescent unsupervised and unchaperoned activities would, logically, have to be banned; or (2) we could arm them with as much information as we can and provide them a sound basis on which to make what, to them, are reasonable and supportable decisions, and we could make sure that the decisions we leave to them are backed up by every reasonable measure to prevent them from getting into trouble as a result of those decisions; or (3) we could go on as we have in the past trying to scare them into conformity and making them suffer the horrible consequences if they choose to do their own thing.

He concludes the second alternative is the sensible approach. (Sussex, Readings, 168)

> If we let our 13 and 14-year-old alone, unsupervised, we've got to equip them with whatever information they need to make the right decisions and to protect them against the undesirable consequences of any wrong ones they may make.

> We don't send a daughter out in the car alone without driving lessons. Why should we send her out ignorant about sex and unprotected against a possible accident.

Planned parenthood supports sex education. They note (The Sex Education approach to Prevention)

> I wonder how many opponents of sexuality education have school-age kids? Even more, I wonder how many of their kids are coming of age today?
>
> I wonder because parents of school-age children are the strongest supporters of sexuality education. A 1981 NBC/ Associated Press Poll showed that more than seven in 10 parents think sexuality education gives students a "healthy view of sex" and that nearly nine in 10 don't buy the opposition's claim that sexuality education encourages sexual relations.

Despite this reported support, it is difficult to pass sex education programs. (Gordon, Readings, 21)

> Eighty percent of the people favor sex education in schools. Why are we losing all the important battles? We are losing the battles because we don't have enough committed people on our side. All it takes in any community is six or seven fanatic people who are opposed to sex education. Boards of education are overly responsive to them, and programs are defeated.

In a research report published in Family Planning Perspectives in May/June 1982, Professors Melvin Zelnick and Young Kim of Johns Hopkins noted, "The data seem to provide overwhelming support for the claim that the decision to engage in sexual activity is not influenced by whether or not teen-agers have had sex education in

school. Young women who have had sex education appear less likely than those who have not to become pregnant if they are sexually active." (Scales, 9?)

Their studies did not find a significant difference between taking a course in sex education and being sexually active.

CARE STAGE

An important decision in the care stage is whether to terminate the pregnancy through abortion or to go through with it. Evidently, these are cultural social class and economic factors correlated with this choice in Connecticut. As noted by Susan Lane (Lane & Browder, 87)

> Most Connecticut families choose abortion for their pregnant daughters. In 1983, of the 9,498 teen-agers who became pregnant in the state, 5,421 opted for an abortion - including over half of the pregnant girls who were 14 or younger. Most doctors feel the percentages are much higher among suburban white girls. "In my practice, 99 percent of the Westport, Fairfield and Darien families I see choose abortion," observes Arndt. "But just two miles away in Bridgeport, you find that 90 percent of pregnant teen-agers don't have abortions. There's a big cultural difference."

FEDERAL AND STATE INTERVENTIONS AT DIFFERENT STAGES

There are currently Federal and State interventions for pregnant teenagers at the care and rehabilitation stages.

Title IX Federal Education Guidelines against sex discrimination as they pertain to educational opportunities for pregnant women problems at particular stages.

Title IX (Timothy)

1. forbids sex discrimination in any educational institution receiving federal assistance. Title IX says that an educational institution receiving federal funds cannot keep any student from participating in a class or extra-curricular activity because of the student's pregnancy, childbirth, false pregnancy, abortion, or recovery unless the student requests otherwise.

2. A school cannot ask a student for a physician's certificate stating that the student is physically and emotionally able to participate in a particular program unless the same certification is required of other students under a doctor's care.

3. If a school operates a special education program for pregnant students, it must be equal to what is offered to non-pregnant students.

4. Schools must treat pregnancy, childbirth, false pregnancy, abortion or recovery the same as it does any other temporary disability regarding services, policy or benefits.

5. If a student's physician requires the student to be absent for a long period of time due to her pregnancy, childbirth, or abortion, the school must allow such leave and the student must be reinstated to the status she had when she began.

6. Students who think they are being or have been discriminated against because of pregnancy should contact their school counselor, their local Board of Education Title IX Coordinator, or the Title IX Coordinator at the Connecticut State Department of Education.

Title IX Federal guidelines relate to school discrimination aspect but do not provide any Federal services or comprehensive approaches to deal with the problems.

STATE LEVEL PROGRAMS

On the state level where coordination is needed and responsibility is clearer, guidelines refer to: (Report, 2)

> ... a variety of state level policies, programs, and services related to this population. The Department of Health Services funds and monitors young parents and adolescent pregnancy prevention programs. The Department of Education, as required by statute, has developed a family life education curriculum guide. Schools are not required to offer such a program, however. The Departments of Human Resources and Income Maintenance offer basic maintenance and/or medical assistance and a range of social services to pregnant teens who meet certain eligibility criteria. There is also one group home in the state for unwed pregnant teenagers who need residential services.
>
> Though there are numerous ongoing activities at the state level, there is no statewide advisory group to coordinate the various efforts. Collaborations between state agencies on this issue have generally been informal in nature.

On the State governmental level, six "raised" bills introduced by Rep. Mary Mushinsky in the 1984-85 session related to stages of Prevention, Care and Rehabilitation for Teenage Pregnancy. These were:

- Two Bills proposed in the Education Committee and raised for hearings:
  - HB 6902 - An Act Establishing a Program of Family Life Education
  - HB 6900 - An Act Concerning School Based Health Clinics
- Two Bills proposed in the Human Services Committee and raised for hearings:
  - HB 6930 - An Act Concerning Medical Assistance for the Working Poor

HB 6931 - An Act Concerning on the Job Training for AFDC Recipients

- Two Bills proposed in the Public Health Committee and raised for hearings:

HB 6936 - An Act Establishing An Adolescent Pregnancy Prevention Grant Program

HB 6937 - An Act Concerning Consent to Pregnancy Prevention Services

Key proposals embodied in these bills, as they pertained to issues in the three stages for intervention, were:

I. PREVENTION STAGE

1.1 FAMILY LIFE EDUCATION COURSES

Mandate K-12 family life education, requiring separate courses between grades 4 and 7.

1.2 TEACHER TRAINING

Require in-service training for all family life education teachers and establish a fund to subsidize localities for the cost.

1.3 CONSULTANTS

1.3.1 Appropriate funds to fill the State Department of Education position of Health Education Consultant.

1.3.2 Create and fund a position of family life education consultant in each of the six regional educational service centers.

1.4 CURRICULUM DEVELOPMENT

Require community advisory councils for curriculum development.

1.5 ADMINISTRATIVE COORDINATION

1.5.1 Institute a state Adolescent Pregnancy Prevention Grant to provide an incentive for communities to coordinate their services.

1.5.2 Establish a Teenage Pregnancy Prevention Council, comprised of state agency heads, representatives of private service agencies and associations, and legislators, to coordinate public and private resources in this area.

II. CARE STAGE

2. HEALTH CLINICS:

CARE & REFERRAL

2.1 Provide planning and development grants to establish two new school-based health clinics, one urban and one rural.

CARE & REFERRAL

2.2 Expand existing school-based health clinics by providing funds to allow full-time operation.

SERVICES

2.3 Adopt a limited "mature minor" statute that would allow a minor to consent to pregnancy prevention services without parental consent.

III. REHABILITATION STAGE

1.1 Budget & Job Training

1.2 Fund the Department of Income Maintenance's FY 1985-86 budget option to increase the Medical Assistance protected income level to 133% of the AFDC standard to ensure that families with medical expenses are better off when working than when on AFDC.

1.3 Sponsor the AFDC and Wagner-Peyser model grant diversion programs for subsidized job training. This program was initially funded (but not implemented) in the FY 1984-85 Department of Income Maintenance budget.

In HB 6902 - Establishing a program of Family Life Education -an attempt was made to provide some form of mandatory coordination, at least for the currently voluntary sex education courses. The Bill was defeated in early May. Along with the 5 other bills pertaining to Teen-age Pregnancy, the Bill suggested mandatory education with local parental and community rights protected. Even those for sex education in schools were concerned by the controversy mandating might bring. The Fact Sheet summary of the bill notes,

- Why mandatory?

  The Task Force recommends a mandatory program, funded by the state, because --

  --teen pregnancy rates are alarmingly high. Existing voluntary programs are insufficient.

  --family life education in Connecticut is spotty. Many towns have no course; other towns, an inferior course.

  --some towns offer the course too late in the child's life to prevent pregnancy.

  --teacher training is often deficient.

  --the cost to the state of foot-dragging is a conservative $50 million/year in welfare and medical payments.

- What about parents' rights?

  The Task Force was very careful to insure family participation and protect parents' rights by these safeguards--

  --parents may exempt their child from the course or portion of any course.

  --each town writes the curriculum itself. The bill only sets the broad list of topics (family life, parenting, human

sexuality, nutrition, decision making).

--each town must use a community advisory council of parents, clergy, doctors, nurses, teachers, and others to develop curriculum and funding proposals.

--councils also promote parent-child discussions on sexuality.

--the program is phased in over 4 years.

- How would it work?

Year one: State Department of Education consultant and 6 regional consultants hired and begin working with communities. Advisory councils set up.

Year two: Curriculum developed and refined by towns. Education of community and parents. Training of teachers.

Year three; Schools begin to implement family life education K-12, with a separate course between grades 4-7.

Year four: family life education mandatory in all Connecticut school systems.

There was concerted vocal antagonism from groups and individuals opposed to these bills, some on principle and others because of the controversy, and they were defeated during the first weeks in May 1985.

From this writer's perspective the establishment of a Task Force to report and lobby for the bills was a suitable approach on higher decision-making levels, but was inadequate for the type of grass roots support needed with this type of controversial issue. Some of the Task Force pronouncements were covered by local media but were not effectively used as position papers to stimulate community participation and discussion.

To this writer, it seemed that rather than including community participation and input, the Task Force remained a seemingly aloof group coming out with legislative proposals, but without grass roots linkage or a cultivated network of support or input.

Planning for the May 23 Conference on Teenage Pregnancy included the hope that appropriate bills would have been passed by the time the conference took place. It is possible that conferences of this sort will be necessary and greater public involvement will be stimulated before there is an attempt to get appropriate legislation in place for 1986.

SOME PROGRAMS FOR PREGNANT TEENS CURRENTLY OFFERED AT LOCAL LEVELS IN THE U.S.A.

There are three types of local agencies providing services for pregnant teenagers. These are schools based, hospital based, and community based agencies.

- School Based Programs

There is no real uniformity or integration of services provided by three different types of agencies, and services delivered can range from good to poor. The bill to have school based clinics (HB 690), would have provided for intervention by the school in the prevention stage. These health clinics (based on the St. Paul Minnesota model), could have referred students to outside clinics for contraceptives, and refer students to other health care providers in case of pregnancy. The success of the St. Paul model was noted in their reduced pregnancy rate

(live births and abortions dropped from 7.9% to 3.5% in 3 years); reduced fertility rate (live births dropped to ½ after 4 yrs. - from 80/1000 to 40/1000); and in the non-recidivism for the 90% of the delivered teens who stayed in school. (87% of pregnant students graduated from high school). The bill sponsors in Connecticut noted that the cost for clinics would be $290,000 while teenage pregnancy costs Connecticut $50 million per year in welfare and medical payments.

Most current school based programs have tried to integrate rather than separate the pregnant teenager out of the regular setting, a far cry from the segregationist view of special schools in the early 1960's.

- Hospital-Based Programs

Some hospitals now offer specialized adolescent obstetrical clinics, and stress education and counseling both in one-to-one sessions with physicians, nurses, and social workers, and in group sessions with other pregnant teens. Clinic hours are often modified to allow pregnant girls to attend school, and clinic personnel may encourage the girls to complete their education.

- Community Agency-Based Programs

Many social service agencies provide individual and group counseling oriented towards the girls' practical concerns and some of these agencies have developed small alternative schools for their clients or establish an on-site clinic facility.

More often a few service are provided on-site but strong referral relationships are sought or developed with other agencies and service providers. At times, these programs are able to provide a variety of services within a single setting, (i.e. counseling, prenatal care, day care, special educational programs, meals, well child chare, etc.)

In neighborhoring New York State, a more effective approach is being heralded. Governor Cuomo recently unveiled a comprehensive integrated program structure for pregnant teenagers, praised both by the Roman Catholic Diocese of Brooklyn and Shirley Gordon, Executive Director of the Family Planning advocates of New York State.

The proposed program will provide more integrated and comprehensive services for pregnant teenagers. (Carroll, New York Times, 3/23/85)

> In a special report on adolescent pregnancy, the state's Council on Children and Families noted that there were 66,399 teen-age pregnancies in the state in 1982, up 11 percent in a decade. It also noted said teen-age pregnancy rates were two and a half times higher among blacks than among whites.
>
> According to the request for proposals circulated last November, the "level of risk" in a neighborhood, a factor in selecting programs to receive grants, would be determined by the poverty level, the percentage of single-parent households and the school dropout rate, as well as the adolescent pregnancy rate.
>
> State money will go to agencies that promise a "full array of services necessary to prevent adolescent pregnancy and to serve pregnant and parenting adolescents."
>
> Miss Margolin declined to describe specific proposals, but she said there had been suggestions for such things as peer counseling, mentor arrangements in which older people

> advise teenagers, counseling of boys as well as girls about sexuality and pulling together of day-care, job-training and job-placement services.
>
> "Kids need a lot more than just birth-control information," said Mrs. Aquila of the Brooklyn Diocese. "Kids need a support system."

In Ebony, Dorothy Height, President of the National Council of Negro Women has called for a more comprehensive and integrated approach for servicing black teenagers. These black teenagers are being hurt the most because of their disproportionate number of births as compared with white teenagers. In 1980, 57% of births to those under 17 in the U.S.A. were to black teens -(Height, 80,-81)

The comprehensive services called for however would benefit all teenagers, irrespective of race, and would provide an integrated means of dealing with a currently fragmented situation and benefiting the total community. It would accept community responsibility for a community generated problem. (Height, 80-81)

> While I do not believe there is a simple answer or solution to this situation, I do believe there are a few basic steps that all of us can and must take. The first imperative for action is education and that includes enlightened school policies. At-risk youths need special incentives to motivate them to stay in school, and teen parents must be offered realistic opportunities to enable them to return to school. In addition to basic education, teen parents need child care, employment, flexible working hours, counselling and a support system of care and nuturing.
>
> As we strive for economic self-sufficiency, we must continue to press our government for job programs which include training in areas designed to meet the requirements of today's labor market. The private sector must be urged to open it

doors so that, once trained, these young people will be given jobs commensurate with their training. Our past experience with job programs has led us to conclude that simply to have a "tuition-free" training program is not enough. The expenditures involved in going to school or in job-hunting, such as local travel expenses, cannot become a burden to an already overburdened individual. And when the teen mother is enrolled in a program, she must be provided with child care.

In addition to the above emphasis, we must aggressively develop more effective sex education strategies and challenge society's silence on the result of sexual activity too early in life. There needs to be a hard look at the sex-charged environment in which children grow up. The time is now for all of us to place our money, time and energy where the need is greatest. We must help teenagers understand the risks. Young children need a clear message to delay sex until they are able to deal with all of its consequences.

Summary -

There is clearly a major teenage pregnancy problem in the United States with symptoms reflected in the State of Connecticut as well. There are varying perspectives on causes and associated factors, and different views as to the most suitable intervention stages. National legislation as well as state and local efforts do not provide the types of comprehensive policy which might deal with the problem. It is hoped that the May 23rd conference will facilitate more effective coordinated effort to overcome fragmented communication and action programs.

With this in mind, interactive modes have been established to at this conference to facilitate the following objectives:

1. To increase effective services for teenagers;
2. Exchange information on issues related to teenagers and services available to help deal with pregnancy related issues;
3. To increase and regularize communication between educators and agencies delivering services in towns and between towns;
4. To exchange information on latest ideas for coping with teenage pregnancy;
5. To provide information on state regulations and state task force on teenage pregnancy recommendations, and
6. To develop an organizational framework for continued education and agency interaction

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APPENDIX A

CONFERENCE
ON
COPING WITH ADOLESCENT PREGNANCY IN THE COMMUNITY

FOR: Educators and service providers

DATE: Thursday May 23, 9:00-3:30

LOCATION: Buley Library, Pajeski Auditorium
Southern Connecticut State University
501 Crescent Street
New Haven, Connecticut 06515

SPONSORS:
1. Area Cooperative Educational Services, Hamden
   Ruth Timothy 288-0517
   and
2. Health Sciences Department, Southern Connecticut State University Moses Stambler 397-4521

SUPPORT: Financial Support by the March of Dimes

PARTICIPANTS: Approximately 200 educators and service providers in Southern and Central Connecticut

PROBLEM FOCUS: The number of pregnancies to adolescents continues to occur in our state at an alarming rate, crossing all ethnic, religious, geographic and socio-economic lines. The problems, consequences, and "costs" of adolescent pregnancy and early child bearing are enormous and impact each of our communities in many significant ways.

It is imperative at this time that educators and community agencies work together to develop new, creative strategies and action plans to address the issue of primary adolescent pregnancy prevention in each of our communities.

OBJECTIVES:
1. To increase effective services for teenagers
2. Exchange information on issues related to teenagers and services available to help deal with pregnancy related issues
3. To increase and regularize communication between educators and agencies delivering services in towns and between towns
4. To exchange information on latest ideas for coping with teenage pregnancy
5. To provide information on state regulations and state task force on teenage pregnancy recommendations
6. To develop an organizational framework for continued education and agency interaction

PROPOSED PROGRAM

8:15 - 8:45 AM	Coffee in Pajeski Auditorium, Buley Library
8:45 - 9:00 AM	Welcome by President Adanti, SCSU Peter Young, Executive Director, ACES Rocco Orlando, Dean, School of Education William Faraclas, Chm., Health Sciences
9:00 - 9:30 AM	KEYNOTE SPEAKER Rep. Mary Mushinsky "State Task Force on Teenage Pregnancy Developments, accomplishments, implications, where do we go from here" (She has presented 7 Bills to the 1985 Legislature regarding recommendations made by the State Task Force on Adolescent Pregnancy)
9:30 - 9:50	SPEAKERS AND AUDIENCE PARTICIPATION 1) Frank Caparulo - New Haven Family Services - "The sexual and educational needs of males and of the retarded." Resources and services available.
9:50 -10:10	2) Mary Jo Peterson - State of Conn. Department of Education - Home Economics Division - "Home Economics resources - A non threatening way for dealing with teen health issues and prevention of Adoles. Preg."
10:10 -10:30	3) Hamden Mental Health - "A local Mental Health services' involvement with school and community groups" Types of resources and services available to school systems/ families/communities/teens/youth bureaus. (Sharon Chattelle)
10:30 -10:50	COFFEE BREAK
10:50 -11:10	4) Betsy Stevenson - Planned Parenthood of Conn. - Resources and services offered besides clinics - e.g. films, speakers, the new "Parent/Child talk to" series. Becoming involved with community planning.
11:10 -11:30	5) Kathy McMann - New England Dairy Council - Nutrition materials and workshops available for school use - (Teen Nutrition/Fad Diets/Anorexia/Pre & postnatal nutrition)
11:30 -12:00	Discussion, Handouts
12:00 - 1:00	Lunch break. College student union will be open (grill, sandwiches, salads, beverages)
1:00 - 1:20	6) Ellen Greist - March of Dimes - Programs available for P.T.A. presentations. Resources available for school use -

AFTERNOON SESSION

1:00 - 1:20 7) Moses Stambler and Mike Perlin - What S.C.S.U. can offer in the way of community assistance and teacher training programs.

1:20 - 1:30 8) Ruth Timothy, "How ACES Can Help"

1:30 - 3:30 FOCUS ON TOWN AND REGIONAL ACTION COMMITTEES - PLANS FOR IMPLEMENTATION

1) Community health, education and social service agencies in specific towns will gather to discuss and plan action programs to meet needs in their own communities

2) Materials will be distributed to assist community action

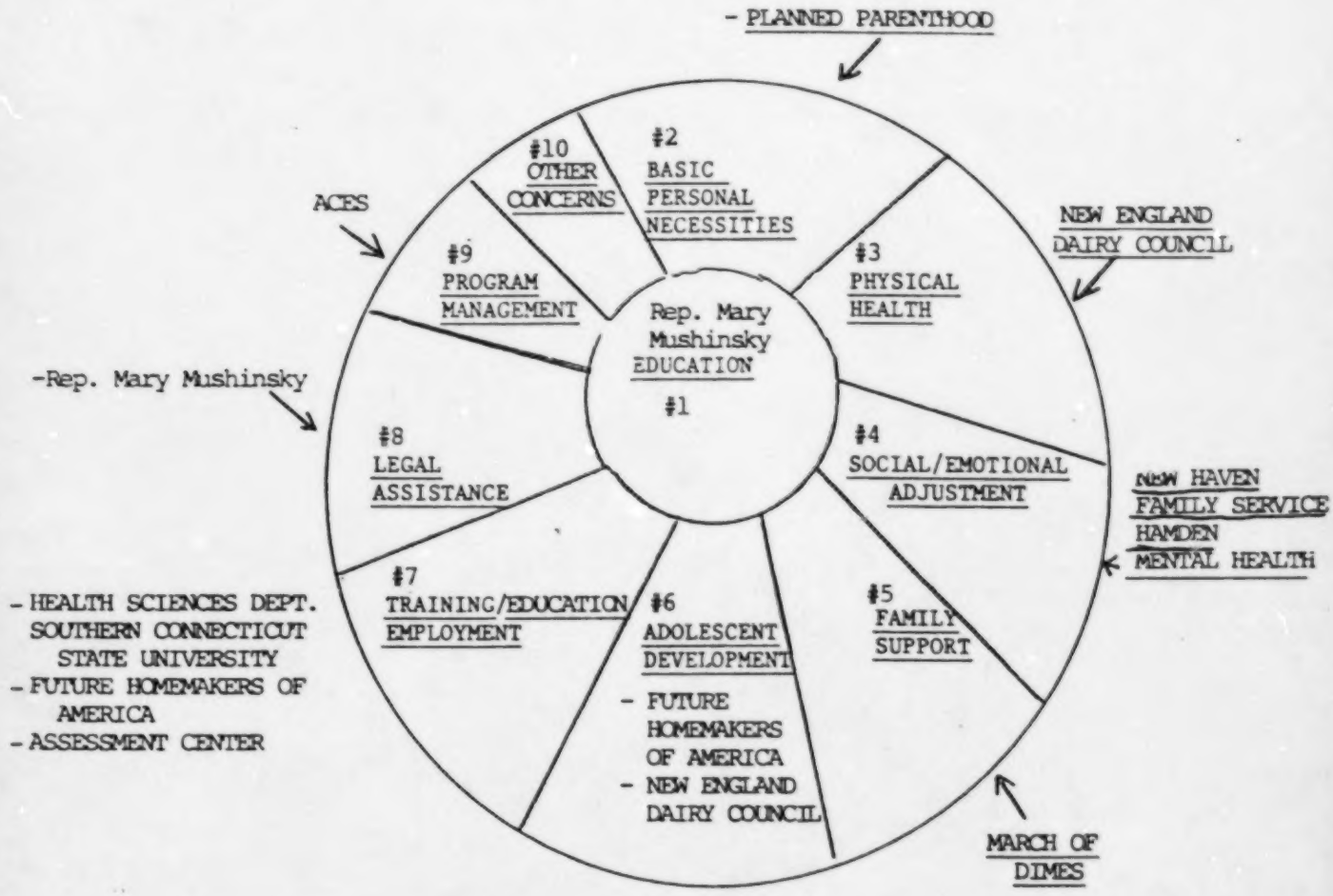
3) Agencies and communities will exchange ideas on their problems, activities and plans.

Contact: ACES, Ruth Timothy, 288-0517
SCSU, Moses Stambler, 389-4323

4/29/85

COPING WITH TEENAGE PREGNANCY
Thursday May 23, 1985, SCSU, Buley Library, Pajeski Auditorium

MAJOR COMPONENTS OF TEENAGE PREGNANCY PROGRAM
USING EDUCATION AS A COMMON FOCUS



A) EDUCATION AS THE CENTRAL COMPONENT: Services related to the general education of normal and special populations.

1. EDUCATION
2. Basic Personal Necessities
3. Physical Health
4. Social/Emotional Adjustment
5. Family Support
6. Adolescent Development
7. Training/Employment
8. Legal Assistance
9. Program Management
10. Other Concerns - (Child Development/Parenthood, Education, Consumer Education, Educational Counseling, Family Life/Sex Education, Home Economics/Home Management, Regular Education Program, Student Financial Assistance)

B) FOCUS FOR PACKETS

1. How to do it
2. Agency involvement in subject areas
3. Town involvement and accomplishments

BEST COPY AVAILABLE

ACES DISTRICTS - TEENAGE BIRTHS

High School Age (13 through 18 yr. only)

Town	1980	1981	1982	1983
Ansonia	22	22	22	20
Bethany	1	1	1	2
Branford	7	9	6	10
Beacon Falls	1	3	2	1
Cheshire	3	5	2	1
Derby	10	9	13	8
Durham	0	2	0	0
East Haven	7	15	8	15
Guilford	6	4	3	8
Hamden	12	13	15	18
Madison	1	1	3	5
Meriden	67	83	64	78
Milford	39	32	27	21
Middletown	29	38	25	26
Middlefield	0	2	0	1
New Haven	402	284	294	449
Naugatuck	18	11	19	16
North Branford	2	4	2	13
North Haven	5	4	2	5
Orange	0	1	3	0
Oxford	2	0	0	3
Prospect	2	2	2	2
Seymour	9	5	8	2
Shelton	9	14	9	10
Stratford	32	30	27	33
Waterbury	145	144	150	175
Wallingford	18	17	22	13
Woodbridge	1	0	0	1
Wolcott	5	6	3	6
West Haven	26	57	44	52

Births & Abortion STATISTICS

From Connecticut State Department of Vital Statistics.

Conn Abortions To Teens	Conn Live Births To Teens	Conn Total conception
1980 - 4404	4269	8673
1981 - 4384	4873	9257
1982 - 4352	5378	9930
1983 4077	5378	9730

APPENDIX B

REGISTRATION FORM - COPING WITH TEENAGE PREGNANCY
SCSU BULEY LIBRARY Thurs. May 23 9-3:30

TO: Agency Head: (The information provided on the sheet will be made available to other participants)

1. Name of Person _____

2. Agency Name, address, phone

3. Check those services provided by your agency

1. __ Education
2. __ Basic Personal Necessities
3. __ Physical Health
4. __ Social/Emotional Adjustment
5. __ Family Support
6. __ Adolescent Development
7. __ Training/Employment
8. __ Legal Assistance
9. __ Program Management
10. __ Other

4. Which additional services should your agency provide _____

5. Which services does your town/region provide? _____

6. Which additional services should your town/region provide? _____

7. What two priority concerns do you wish to focus on at this conference?

8. What problems are you facing in assisting pregnant teenagers in your town area? What can be done to resolve these problems?

REGISTRATION PROCEDURE

Return this Registration from plus $1 (to help defray coffee break refreshment costs) to: Ruth Timothy
Area Cooperative Educational Services
205 Skiff Street
Hamden, Connecticut 06517